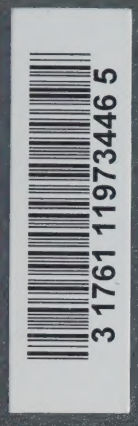


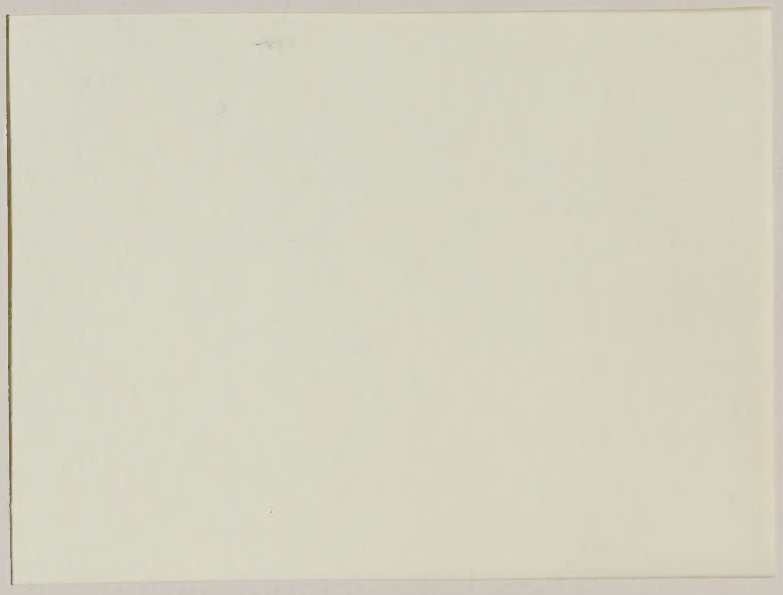
PRESENTATION TO THE ROYAL COMMISSION ON NEW REPRODUCTIVE TECHNOLOGIES

October 1990

ONTARIO
ADVISORY COUNCIL
ON WOMEN'S ISSUES

CONSEIL CONSULTATIF
DE L'ONTARIO SUR LA
CONDITION FÉMININE

880 rue Bay Street, 5th floor/5e étage, Toronto, Ontario, M7A 1N3 (416) 326-1840 Fax/Télécopieur: (416) 326-1836 TDD/ATM: (416) 326-1835



PRESENTATION TO THE ROYAL COMMISSION ON NEW REPRODUCTIVE TECHNOLOGIES

October 1990

ONTARIO ADVISORY COUNCIL ON WOMEN'S ISSUES

CONSEIL CONSULTATIF DE L'ONTARIO SUR LA CONDITION FÉMININE

880 rue Bay Street, 5th floor/5e étage, Toronto, Ontario, M7A 1N3 (416) 326-1840 Fax/Télécopieur: (416) 326-1836 TDD/ATM: (416) 326-1835

PRESENTATION TO THE ROYAL COMMISSION ON NEW REPRODUCTIVE TECHNOLOGIES

October 1990

Prepared by

The Ontario Advisory Council on Women's Issues

COUNCIL MEMBERS

Sandra Kerr, President, Oakville
Susan McDonald, Vice-President, Arva
Marielle Cousineau, Kapuskasing
Margot Dallaire, Sudbury
Bernice Dubec, Thunder Bay
Mila Eustaquio, Mississauga
Dianne Harkin, Winchester
Kathleen Lahey, Kingston*
Catherine McPherson, Toronto
Sarah Melvin, Sioux Lookout
Lana Mitchell, North Bay
Helen Penfold, Owen Sound
Carol Anne Sceviour, Toronto
Lucya Spencer, Ottawa
Lynn Zimmer, Peterborough

STAFF

Elayne Ceifets, Acting Executive Officer
Lydia Oleksyn, Communications Officer
Melissa Hogg, Policy Advisor
Melody CarvalhoMount, Administrative Assistant
Julie Radway, Receptionist

**Denotes members whose term ended prior to the completion of the paper.*

TABLE OF CONTENTS

Executive Summary..... i

Summary of Recommendations..... iv

Introduction..... 1

Need for Comprehensive Legislation..... 3

Reproductive Contracts..... 7

Alternative Insemination..... 25

Fertilization Technologies..... 36

Conclusion..... 45

Appendix..... 47

Glossary..... 50

Endnotes..... 55

EXECUTIVE SUMMARY

The Ontario Advisory Council on Women's Issues was established at arms-length from the government in 1973, and has the unique right to review and make recommendations on government direction and policies. Council's mandate is to advise the Ontario government on all matters pertaining to the achievement of economic, social and legal equality for women; to respond to requests for advice and consultation from the Minister Responsible for Women's Issues; to hold public meetings with the purpose of stimulating public discussion and accessing the opinions of women; to identify the specific areas requiring the attention of government and to recommend legislation and program changes to the Minister Responsible for Women's Issues. There are 15 members, all of whom are appointed by Cabinet on a part-time basis. Meetings are held in Toronto and work on identified issues done through committees. Council brings a balance of women's views from across the province to the government's attention.

The Advisory Council takes the position that technological interventions into reproduction are essentially women's issues, but we note that none of the policy and legislative documents dealing with these issues have considered women's experiences of infertility, technology, and law as being particularly relevant to their inquiries. Instead, the overwhelming focus in these policy inquiries has tended to be the concerns of the medical practitioners, lawyers, and technicians who are developing and delivering these technologies.

We have chosen to examine the aspects of "reproductive technology" which raise the most urgent issues for women in Ontario:

1. The use of contracts to hire the reproductive services of women;
2. Restriction on access to and parentage issues arising from the use of alternative insemination[1];
3. The increasing use of fertilizations technologies to create pregnancies.

Reproductive Contracts: The recommendations are aimed at securing the mother-child relationship, preventing the trafficking of women and children, securing the biological parties from prosecution, undoing the effects of the contracts and creating disincentives for entering into reproductive contracts.

Alternative insemination: Sperm donation and alternative insemination are noninvasive, low-risk procedures which meet the fertility needs of a diverse population. Alternative insemination itself poses no discernable harms to women and children, and, therefore, our recommendations ensure full access to the procedure, protect the mother-child relationship, and guard against discrimination.

Fertilization technologies: The Advisory Council is strongly of the opinion that in vitro fertilization is a misallocation of important financial and human resources. The emotional appeal of biological reproduction remains strong, but it is difficult to justify the use of IVF when the visible costs can run up to a minimum of $10,000 per attempted conception and the costs of developing and maintaining this technology are similarly high. Central to our recommendations is the call for a moratorium on IVF.

Women face risks and experience harms in the use of these technologies. Many could be reduced or averted by making sensible policy choices that take those risks and harms into account. These choices should be made in the form of coherent legislation, not left to the vagaries of private and public dispute-resolution mechanisms.

Summary

The recommendations that we make puts the focus in reproduction back where it belongs: in priorizing the health and security needs of birth mothers, their children, and birth families, and in discouraging the use of contracts or technologies that commodify women or children.

In addition, the Advisory Council strongly urges the Royal Commission to build in a "discussion" phase of its report prior to the submission of its final report to the government. This would allow women's groups and others who were unable to make thorough presentations due to either time constraints or lack of expertise within their membership, the opportunity to make a more comprehensive statement to the Commission on these important and far reaching issues.

SUMMARY OF RECOMMENDATIONS

NEED FOR COMPREHENSIVE LEGISLATION

RECOMMENDATION 1

That the provincial and federal governments co-operate in enacting a coordinated scheme of legislation relating to reproductive contracts, in vitro fertilization (IVF), and alternative insemination (AI) that priorizes the concerns and needs of women and children affected by these practices and arrangements to ensure that patchwork and inconsistent law reform does not take place.

RECOMMENDATION 2

That the new legislation include a preamble that recognizes these fundamental principles:

(a) that women are entitled to autonomous control of their own reproductive capacities;

(b) that women are not reproductive chattels or experimental subjects for pharmaceutical products or medical procedures, and that all reproductive technologies should respect the integrity and dignity of women;

(c) that governments have a responsibility to educate society to recognize individual roles beyond the stereotyped ideals of marriage and parenthood;

(d) that the rights of birth mothers are inalienable, and are not to be commercialized or fragmented;

(e) that contracts to bear a child/children for another person or persons are null and void as against public policy;

(f) that all reproductive services authorized under this legislation will be available to all adult women without discrimination on the basis of geographic location,

marital status, sexual orientation, reproductive status, economic condition, physical or mental ability, race, age, or the consent of their partner;

(g) that decisions about allocation of resources to reproductive technologies will be made in light of the costly, risky, and experimental nature of most such technologies, and also in light of the disadvantaged position of women and children in Canadian culture.

REPRODUCTIVE CONTRACTS

RECOMMENDATION 3

That comprehensive new legislation be introduced to counter pressure on women to provide reproductive services. This legislation should contain the following provisions:

(a) all reproductive contracts are null and void as against public policy;

(b) the birth mother of a child/children born as the result of a purported reproductive contract is the only legal parent of such a child, subject to recommendation (c);

(c) the birth mother of a child/children born as the result of a purported reproductive contract may, by the performance of some affirmative act(s) before the child becomes three years of age, cause her partner to be recognized as a legal parent of such child(ren);

(d) it is a criminal offense to promote a reproductive contract, whether through advertising, in the practice of a profession, or through an incorporated or unincorporated organization;

(e) any person(s) who seek to enforce a purported reproductive contract against a woman may be subject to an injunction or to an order for damages in an action brought by the woman and/or her child/ren;

(f) the biological parties to a reproductive arrangement and their partner(s) are exempt from such criminal or civil liability, except insofar as injunctive relief is sought.

RECOMMENDATION 4

That "reproductive contract" be expressly defined in all new legislation as any form of reproductive arrangement in which a woman agrees to bear a child for a person (or persons) who is not her spouse or cohabitant, with the intention that the child will cease to be her child and become the child of that person (or persons), whether or not that person or persons have contributed ova, sperm, or embryos used in creating the pregnancy, and whether or not that person or persons have paid or agreed to pay any fees, expenses, or any other monies for the woman's reproductive services, ova, or embryos.

RECOMMENDATION 5

That the Criminal Code be amended to provide that anyone is guilty of an offense who promotes a reproductive contract or provides services toward the formation or execution of such contract for a fee; and that the amendment expressly exclude from criminal liability any biological or marital party to a purported reproductive contract.

RECOMMENDATION 6

That new provincial legislation be enacted to provide that lawyers, medical practitioners, and other professionals who knowingly provide services in relation to promoting or arranging a reproductive contract are engaging in unprofessional conduct and that the province amend the relevant legislation accordingly.

RECOMMENDATION 7

That the new provincial legislation declare all reproductive contracts to be null, void, and unenforceable as against public policy.

RECOMMENDATION 8

That the legislation recognize the birth mother's parental status as inalienable.

RECOMMENDATION 9

That the legislation provide that the existence of a purported reproductive contract cannot be treated in legal proceedings as evidence of the birth mother's abilities as a parent or the best interests of the children; but can serve only as evidence that the birth mother of the child(ren) in question is the legal parent.

RECOMMENDATION 10

That the birth mother may take affirmative steps to cause her partner to be recognized as the other legal parent of the child.

RECOMMENDATION 11

That the legislation include a provision that a donor of sperm, ova, or embryos, or a party to a purported reproductive contract, cannot apply for a declaration of paternity or maternity of a resulting child, nor be considered to be a parent to the resulting child merely on the basis of biological/genetic connection, contractual expectations, or performance of contract.

RECOMMENDATION 12

That the parentage provisions in recommendations seven through 11 apply for all legal purposes, including but not limited to: adoption; intestate or testate succession; support, custody, access, or visitation; probate law exemptions, allowances, or other protections for children in parent's estates; social benefits; next-of-kin provisions; and donative transfers to children as a class.

RECOMMENDATION 13

That the legislation should provide that the birth mother may bring an action for damages or an injunction, including costs of the action, in the following circumstances:

(a) against any person who attempts to enforce a reproductive contract, or who seeks a declaration of paternity or maternity on the basis of donated reproductive material, or who seeks adoption, custody, or visitation through the legal process, merely on the basis of donated gametes, in proceedings contested by the birth mother;

(b) against any person who seeks to waive the birth mother's right to consent to adoption, unless such waiver is sought in the context of care and protection proceedings;

(c) against any person who seeks to exercise surveillance over a woman's health or medical practices during conception, pregnancy, labour, childbirth, or lactation, whether on the basis of a reproductive contract or other arrangements;

(d) against any person who solicits or requests a woman to engage in a reproductive contract, including her partner or any other member of her family;

RECOMMENDATION 14

That the legislation should provide that birth mothers are not liable in relation to the following matters:

(a) any actions for the refund of any money that may have been paid either as fees or as expenses in relation to a purported reproductive contract;

(b) any actions for failure to perform an undertaking under a purported reproductive contract, frustration of contract, or similar action, whether the remedy sought is specific performance or money damages.

ALTERNATIVE INSEMINATION

RECOMMENDATION 15

That new legislation be enacted which guarantees access to alternative insemination to all adult women as a matter of choice and not subject to discrimination by virtue of unproven fertility, marital status, reproductive history, physical or mental disability, race, sexual orientation, age, or economic condition.

RECOMMENDATION 16

That the Ontario Human Rights Code (OHRC) be amended to provide that a medical practitioner who discriminates on the basis of unproven fertility, marital status, physical or mental disability, race, sexual orientation, age, or economic condition in relation to access to AI has engaged in discrimination on the basis of sex, sexual orientation, race, or age under the OHRC, and further, that the relevant professional legislation be amended to provide that it constitutes unprofessional conduct for purposes of determining professional sanctions.

RECOMMENDATION 17

That medical practitioners be prohibited from using fertility drugs in conjunction with AI unless they are unquestionably necessary and the woman receives full, timely, and understandable information on the experimental nature and the "side effects" of these drugs.

RECOMMENDATION 18

That new legislation provide for access to banked sperm and sperm testing services for all adult women, whether or not they are using the services of a medical practitioner.

RECOMMENDATION 19

That sperm testing protocols be developed to ensure that carriers of sexually and other genetically transmitted diseases do not transmit them in sperm samples.

RECOMMENDATION 20

That the new legislation provide that "medical practitioner" include licensed midwives.

RECOMMENDATION 21

That all fertility services related to alternative insemination, including the actual insemination as well as all the allied procedures (collection, testing, freezing, and transportation of sperm; any diagnostic procedures that might be required; etc.) be fully covered medical services under the Ontario Health Insurance Plan, without discrimination by geographic location, marital or reproductive status, sexual orientation, race, age, physical or mental disability, or economic condition.

RECOMMENDATION 22

That the new legislation recognize the legality of private alternative insemination arranged between consenting adults.

RECOMMENDATION 23

That new legislation be enacted to provide that except for children conceived by alternative insemination and born to women living as single women at the time of birth, the parents of the child shall consist of the birth mother and her partner, whether they are married or unmarried, and whether they are of the opposite sex or of the same sex, if the birth mother has performed one or more affirmative acts after the birth of the child to cause her partner to be recognized as a legal parent of the child(ren). (A detailed description of affirmative acts is found in the rationale of Recommendation 10).

RECOMMENDATION 24

That the new legislation should provide that the sperm donor is not a parent to any resulting AI child, whether "paternity" can be established or not, and that no sperm donor may bring an application for the determination of paternity, or for custody or visitation, or is liable for support, on the mere basis of having donated sperm.

RECOMMENDATION 25

That the new legislation provide that no one can become a parent to an AI child merely by virtue of performing insemination as a medical practitioner, midwife, friend, or relative, but that evidence that the birth mother's partner has performed or participated in the AI process can be admitted as relevant to establishing the birth mother's intention to involve her partner in a parental capacity.

RECOMMENDATION 26

That new legislation provide that the birth mother of an AI child may register both herself and her partner, whether married or unmarried, and whether of the same or the opposite sex, as parents of the child. Consent of her partner is required only if she is unmarried.

RECOMMENDATION 27

That the regulations governing sperm banks be amended to provide for the creation of databases to link donor, recipient, and birth information for purposes only of making genetic and health information available to children born as the result of AI, and that such records be kept for a minimum of 100 years.

RECOMMENDATION 28

That new legislation secure the confidentiality of sperm donors by providing that the identity of the sperm donor(s) or recipients cannot be disclosed to the child as per current Ontario Adoption Laws.

RECOMMENDATION 29

That legislation and regulations relating to the licensing and operation of sperm banks be amended to provide for the provision of two levels of confidentiality: absolute confidentiality, as described in recommendation 28 above, and conditional confidentiality, where donors have elected to allow their identity to be disclosed to any resulting children after they are 18 years of age.

FERTILIZATION TECHNOLOGIES

RECOMMENDATION 30

That provincial governments should impose a moratorium on the use of fertilization techniques, except for experimental purposes; that a special committee be appointed to conduct a public review on the results of these experiments and the risk levels of the medical and drug therapies involved to determine acceptable levels; and that this committee be made up of feminists, medical personnel, lawyers and lay persons.

RECOMMENDATION 31

That new legislation should prohibit the use of human gametes for any procedure other than alternative insemination, whether by a laboratory technician or a medical practitioner, with the intention of achieving pregnancy, unless the institution within which the procedure is carried out takes full responsibility for fully disclosing all the physical and psychological risks of the procedure(s) to the women involved, and for any harm that may occur immediately or at any point in the future to the women involved or to their resulting children.

RECOMMENDATION 32

That banking of human embryos be prohibited; that human ova be cryopreserved only for individual women, and not be made the subject of donations or commercial traffic; that the practice of hormonal stimulation to produce multiple ova during each menstrual cycle be prohibited.

RECOMMENDATION 33

That existing cryopreserved ova and embryos be treated as the sole responsibility of the woman who contributed them, should any dispute over their control or disposition develop, and, where the donor woman cannot be identified with reasonable certainty, they may not be used in any medical or research procedure but should be destroyed.

RECOMMENDATION 34

That frozen embryos in any stage of development or division are not juridical persons, have no rights under any law of Canada, and have none of the incidents of legal personality.

RECOMMENDATION 35

That a special committee be appointed to develop monitoring protocols of women and children who have been affected by fertilization techniques, to collect information on the short-term and long-term effects of those procedures and drugs, and to inform women of these findings; and this committee be made up of feminists, medical personnel, lawyers and lay persons

RECOMMENDATION 36

That new legislation be enacted to secure the parentage of children born as the result of IVF, with the birth mother to be recognized as the only legal parent of such child, unless she takes affirmative steps to cause her partner at the time the child is born to be recognized as the other legal parent (consent of her partner is required only if she is unmarried). Under this legislation, no person, merely by virtue of donating sperm, ova, or embryos, accedes to the status of parent.

RECOMMENDATION 37

That new legislation be adopted which provides women and children with an action for damages caused by any procedure or drug used in attempting or achieving pregnancy by in vitro fertilization, whether or not that woman has signed a consent to the procedure or drug; and even if that woman has, on her own behalf or on behalf of such child, waived any action for damages in writing or otherwise.

RECOMMENDATION 38

Recognizing that access to fertilization technologies will be significantly curtailed, accessibility should be determined according to need, and those women who most likely would not be considered qualified to adopt children (disabled, single, lesbian and older women, and women with the most serious fertility impairments) should receive priority.

INTRODUCTION

The status of Ontario's women continues, to a large extent, to be determined by their reproductive responsibilities and vulnerabilities. Interest in having one's "own" children has been intensified by the perceived success of new reproductive technologies, which seem to meet needs that older practices of adoption and fostering children have not. These new "technologies" include artificial insemination, in vitro fertilization, embryo creation, freezing, and implantation, and a range of reproductive services, from donation of eggs and sperm to gestation and birthing.

At the present time in Ontario, as in most other industrialized countries, reproductive technologies are unregulated by the government and involve a confusing, contradictory, and incomplete patchwork of medical practices, administrative regulations, laws, judicial decisions, and beliefs, most of which predated the widespread use of technologies in reproduction. There has been considerable interest regarding the role of law in relation to reproductive technologies, and innovative policy recommendations have been put forward in various jurisdictions.

In response to growing concern about these "technologies," the Ontario government in 1985 published a report by the Ontario Law Reform Commission on reproductive technologies,[2] as have other jurisdictions and policy bodies in Canada.[3] But fundamental ethical and policy issues remain unresolved in Ontario.

In the meantime, courts and private citizens have been left to grapple with the growing number of human issues that are generated by the use of these technologies. The number of uncertainties posed by these practices are increasing daily. Not surprisingly, the "losers" in the day-to-day practice of reproductive technologies have tended to be women -- especially women who face additional disadvantages because they are Native Canadian, visible minority or immigrant women, or because of their race, disability, sexual orientation, or economic status.

The Ontario Advisory Council on Women's Issues takes the position that technological interventions into reproduction are essentially women's issues. We note, however, that none of the policy and legislative documents dealing with these issues have really considered women's experiences of infertility, technology, and law as being particularly relevant to their inquiries.[4] The overwhelming focus in these policy inquiries has tended to be the concerns of the medical practitioners, lawyers, and technicians who are developing and delivering these technologies.

It appears that infertility and new reproductive technologies are pre-occupations of the "white culture". Native people tend to approach infertility quite differently. If a Native couple were experiencing difficulties conceiving a child, someone in the extended family would give one or two of their own children to the couple to raise as their own.

The Ontario Advisory Council on Women's Issues has identified three aspects of "reproductive technology" which raise the most urgent issues for women in Ontario:

1. **The use of contracts to hire the reproductive services of women ("surrogacy" contracts);**

2. **The increasing use of IVF (in vitro fertilization) and similar techniques to create pregnancies;**

3. **Access and parentage issues arising from the use of alternative insemination (also known as artificial insemination or AI).**

Women face risks and experience harms in the use of these technologies. Many of these could be reduced or averted by making sensible policy choices that take into account those risks and harms. These choices should be made in the form of coherent legislation, not left to the vagaries of private and public dispute-resolution mechanisms.

NEED FOR COMPREHENSIVE LEGISLATION

RECOMMENDATION 1

That the provincial and federal governments co-operate in enacting a coordinated scheme of legislation relating to reproductive contracts, in vitro fertilization (IVF), and alternative insemination (AI) that priorizes the concerns and needs of women and children affected by these practices and arrangements to ensure that patchwork and inconsistent law reform does not take place.

RATIONALE

Presently in Ontario, legal and ethical policies pertaining to reproductive contracts, IVF, and access to AI are located in confusing and contradictory places.

According to Ontario courts, Ontario is one of the few jurisdictions in North America that will legally recognize contracts to bear children,[5]. The Ontario Law Reform Commission has proposed an elaborate legislative scheme to allow judges to supervise women who bear children under contract.[6] Along with other Canadian jurisdictions, Ontario is importing Australian IVF technology at a fast pace. But the regulation of these practices is left to the ethical and professional constraints of the medical and scientific community. Aside from the regulations that apply to licensed sperm banks, IVF and similar technologies operate in a legal vacuum. Access to reproductive technologies theoretically is subject to the nondiscrimination provisions of the Ontario Human Rights Code, but in reality, medical practitioners hold a virtual monopoly over access under the guise of making decisions about "medical necessity" -- decisions which by their very nature cannot be appealed in any practical sense.[7]

General law and professional ethics have failed to integrate these issues relating to reproductive technologies. Family law, adoption law, and child welfare law do not take account of reproductive contracts, IVF, or AI, yet their sometimes competing policies are relied upon for legal solutions when nothing else seems to apply. The

implications of reproductive technologies for government benefits and services eligibility, support, and immigration status have not been rationalized with other areas of legal policy. And the more general concerns of budgetary and health care priorities have not been touched in law or in professional ethics.

Women and children are most obviously disadvantaged and vulnerable by the lack of legal and ethical policies. Therefore, it is urgent that new legislation focus on their needs and concerns, especially since these have largely been ignored by the courts and professionals who control existing law and practices.

The Advisory Council recognizes that the constitutional division of powers between the provincial and federal governments makes it unlikely that either level of government will be able to enact legislation that will address all the legal issues presented by reproductive technologies. However, the Council also recognizes that there are enough overlapping and coordinate areas of jurisdiction that would allow either level of government to take the leadership role in enacting comprehensive legislation. Because the federal government has exclusive jurisdiction over criminal matters and some jurisdiction over family matters, the Council looks to the federal government to provide that leadership.

RECOMMENDATION 2

That the new legislation include a preamble that recognizes these fundamental principles:

(a) that women are entitled to autonomous control of their own reproductive capacities;

(b) that women are not reproductive chattels or experimental subjects for pharmaceutical products or medical procedures, and that all reproductive technologies should respect the integrity and dignity of women;

(c) that governments have a responsibility to educate society to recognize individual roles beyond the stereotyped ideals of marriage and parenthood;

(d) that the rights of birth mothers are inalienable, and are not to be commercialized or fragmented;

(e) that contracts to bear a child/children for another person or persons are null and void as against public policy;

(f) that all reproductive services authorized under this legislation will be available to all adult women without discrimination on the basis of geographic location, marital status, sexual orientation, reproductive status, economic condition, physical or mental ability, race, age, or the consent of their partner[8];

(g) that decisions about allocation of resources to reproductive technologies will be made in light of the costly, risky, and experimental nature of most such technologies, and also in light of the disadvantaged position of women and children in Canadian culture.

RATIONALE

We propose that any new legislation contain a preamble with a statement of fundamental principles to educate the public and to interpret the statutes and regulations.

All new legislation should clearly state that it is intended to recognize certain fundamental values in relation to human reproduction, and that the legislation reflects community values. These values focus on women's inescapable responsibility for reproduction, and their resulting vulnerability to reproductive exploitation.

Recognition of these values in legislation will facilitate adjustment to the fact that all women are fully equal members of society, with important rights and prerogatives, and that children who are born as the result of reproductive technologies or arrangements are not commodities.

Points (f) and (g) of Recommendation 2 may well seem to be controversial to some, but in fact they are nothing more than the rights guaranteed by the Canadian Charter of Rights and Freedoms and other human rights documents. The last principle is intended to promote the full achievement of equality in Canada, because it would guarantee reproductive technologies access to those whose chances of reproducing biologically or through adoption are perhaps the smallest.

REPRODUCTIVE CONTRACTS

The Advisory Council is strongly of the opinion that Ontario women should not be made vulnerable, by lenient courts and professional bodies, to exploitation for reproductive services, whether that exploitation is carried out by way of contract, statute, regulation, medical practice, or judicial fiat.[9] Therefore, the Advisory Council rejects all approaches to the regulation of reproductive contracts that would legitimize contracts executed, for example, under judicial supervision, or that are enforceable subject to vague and indeterminate standards such as the "best interests of the child."

Legally, six major approaches have evolved over the last five years to address issues relating to reproductive technologies. Each approach would have a slightly different impact on women's reproductive choices and vulnerabilities. This discussion highlights the main features of each approach, along with its advantages and disadvantages for women and children. Recommendations three through 14 represent the Advisory Council's position on the issues raised by each of these six approaches.

- **Blanket criminalization** would criminalize all reproductive arrangements of the "surrogate mother" type.[10]

  Advantage: This approach makes a very clear policy statement.

  Disadvantage: It would make every woman's pregnancy a potential focus for criminal investigation, increase the surveillance of pregnant women as a class, and expose women who are participate in contracts to more certain criminal liability than the other parties.

- **Criminalization of parties** would assign criminal liability to every reproductive contract participant except the biological parties to the contract, and their partners.[11]

Advantage: It would still make a very clear policy statement, but it would also ensure that pregnant women do not become the disproportionate focus of enforcement efforts.

Disadvantage: Individuals may still enter into such contracts without criminal liability. This would leave women open to financial coercion or pressure from relatives. However, other provisions could affect this balance of power.

- **Woman-empowering** would use civil legislation to prevent the parties from achieving the result they are seeking unless the woman who is the proposed birth mother consistently and meaningfully consents to the arrangement throughout the course of the transaction.[12] Civil provisions could be used to declare reproductive contracts to be of no force or effect;[13] to give women the legal right to prevent other parties from seeking to enforce a supposed contract; and to give women and children involved in reproductive contracts the right to sue for any actual or deemed harm caused by the contract or by attempted enforcement of a contract.

  Advantage: It would specifically articulate the social and gender harms and would form a legislative framework of rights within which women could make individual choices. It avoids the potential harm of disproportionate criminal enforcement against women who render reproductive services.

  Disadvantage : It would leave the choice of whether to provide reproductive services up to individual women who, at the time they enter into an arrangement, might not be empowered enough to be able to act on their actual legal rights. Thus women might still remain vulnerable to involvement in these contracts because of poverty, emotional attachment, relations of domination, or other forms of duress.

- The **Adoption model** would assimilate all reproductive contracts to existing adoption law. This would give birth mothers who are involved in reproductive contracts the same right as other birth mothers to withhold or revoke consent to adoption within a specified period of time after placing their child for adoption.[14]

  Advantage: This approach goes directly to the question of whether birth mothers involved in reproductive contracts can be compelled to surrender custody or parentage of their children. The birth mother retains the essential legal incidents of maternity until they are voluntarily terminated after she has given birth.

  Disadvantage: It does not reach the complicating issue of the purchasing sperm donor's legal relationship to a child who remains with a birth mother who does not consent to adoption: Is the purchasing sperm donor the legal father, with parental rights of custody or visitation? Is the purchasing donor in the same position as any other sperm donor, who is ordinarily presumed to have no more connection with the child than a stranger? What is the relationship between the purchasing donor's wife and the child? What is the relationship between the birth mother's partner and the child? Children born into these situations might well be custodially embattled from birth because the adoption model does not resolve the crucial issue of the child's legal parentage in all respects. It ensures only that the birth mother would be able to retain her legal status as mother, and it would probably ensure that the birth mother would be able to retain custody of the disputed child during infancy, but not necessarily throughout childhood.

- **Best interests of the child** focuses primarily on issues of legal parentage, custody, and access, rather than ensuring that women are not made vulnerable to participation in reproductive contracts. Using the family law concept of the "best interests of the child," statutory versions of the best interests test have been fashioned to settle competing claims to children who have been born under

reproductive contracts.[15] Unlike the family law best interests test, however, these statutes tend to priorize biological connection and material wealth. These factors would favour the purchasing sperm donor in a custody suit, and are open to manipulation against the interests of women.

Advantages are hard to envision. This approach does not empower or protect women per se, but virtually ensure that a birth mother will be forced to undergo protracted, expensive, and traumatic litigation to retain her legal parentage and custody. There is no guarantee that if she chooses litigation, the outcome will be any more favourable.

Disadvantages relate to the process forced on the birth mother and to the division of the child's time between two households literally from birth. The latter point is of special concern, since there is at present no reliable research data on the effects such a lifestyle might have on child development.

- **Common law**: None of these approaches would necessarily nullify the growing common law of reproductive contracts, unless the legislation were to make special provision for each feature of the common law that is being changed. At present, the common law is indeterminate as to legal parentage and custody,[16] favourable to access claims of birth mothers who have lost custody after birth,[17] favourable to sperm donor's access claims when the birth mother has promoted a relationship between him and the child,[18] and undecided whether it is acceptable to give a contract child more than two parents. New variations on basic questions of parentage, custody, access, and support are reaching the courts every month, and this promises to be the area that will attract the most litigation. However, noncontested cases of adoption following a birth mother's surrender of a contract child are also generating mixed results in the courts, which creates another area of uncertainty in relation to parentage and support.[19]

Advantage: Leaving all issues relating to contract reproduction to the courts means that each unique case will be treated on its own merits and with as much justice as the individual judge can bring to it.

Disadvantage: It will likely be years or even decades before the volume of litigation produces a definitive body of legal rules. Even then, however, competing lines of authority will probably emerge, which legislatures will have to reconcile with statute law.

RECOMMENDATION 3

That comprehensive new legislation be introduced to counter pressure on women to provide reproductive services. This legislation should contain the following provisions:

(a) all reproductive contracts are null and void as against public policy;

(b) the birth mother of a child/children born as the result of a purported reproductive contract is the only legal parent of such a child, subject to recommendation (c);

(c) the birth mother of a child/children born as the result of a purported reproductive contract may, by the performance of some affirmative act(s) before the child becomes three years of age, cause her partner to be recognized as a legal parent of such child(ren);

(d) it is a criminal offense to promote a reproductive contract, whether through advertising, in the practice of a profession, or through an incorporated or unincorporated organization;

(e) any person(s) who seek to enforce a purported reproductive contract against a woman may be subject to an injunction or to an order for damages in an action brought by the woman and/or her child/ren;

(f) the biological parties to a reproductive arrangement and their partner(s) are exempt from such criminal or civil liability, except insofar as injunctive relief is sought.

RATIONALE

The Advisory Council is strongly of the opinion that reproductive contracts should be seen as contrary to public policy and the well-being of women and children in Ontario. The clearest statement of their unacceptability would be to include provisions in the Canadian Criminal Code and place the enforcement power of the government behind this principle. However, the Advisory Council is also strongly of the opinion that to make women, sperm, ova, embryo donors, or the partners of those persons, liable to criminal prosecution would be to expose an already vulnerable sector of the population to additional pressure, manipulation, and control, to no good effect. Thus those parties should be exempt from criminal liability. In contrast, publically-licensed professionals such as medical practitioners and lawyers should be subject to criminal sanction because they have the direct power to create opportunities for reproductive contracts.

Experience in other jurisdictions has already shown that by itself, criminalization of reproductive contracts will not be sufficient to prevent the formation of such contracts, nor prevent women and children affected by them from becoming enmeshed in destructive and explosive personal and legal conflicts. Thus criminalization should be complemented by a declaration in civil law that such contracts are of no force and effect. This would prevent the use of legal machinery to enforce contract terms undertaken by the parties in defiance of criminal law. It should also be complemented with legislation which conclusively provides that the birth mother of children born under such contracts is the legal parent of that

child(ren), together with her partner, if she has carried out any affirmative acts to cause her partner to stand in the position of legal parent. This would ensure that every child born to a birth mother who decides to retain parentage and custody of that child will be able to provide the child with a secure mother-child relationship. This relationship would of course be subject to the subsequent conduct of the birth mother and ordinary principles of family and child welfare law, but during the important post-birth and early attachment period, the security of that relationship would be treated as a paramount value.

The rest of the recommendations in this section elaborate on this overall approach. The Advisory Council rejects any suggestion that current judicial law provides a satisfactory legal framework, or that approaches which legitimize or merely regulate reproductive contracts are at all acceptable to women and children. Those approaches flagrantly disregard the very real interests of children by treating them as affectional chattels, and they treat women as reproductive chattels.

RECOMMENDATION 4

That "reproductive contract" be expressly defined in all new legislation as any form of reproductive arrangement in which a woman agrees to bear a child for a person (or persons) who is not her spouse or cohabitant, with the intention that the child will cease to be her child and become the child of that person (or persons), whether or not that person or persons have contributed ova, sperm, or embryos used in creating the pregnancy, and whether or not that person or persons have paid or agreed to pay any fees, expenses, or any other monies for the woman's reproductive services, ova, or embryos.

RATIONALE

The scope of the legislation must be wide enough to reach all forms of agreements, whether or not they are for pay. To make exceptions for unpaid reproductive services or for women who are the gestational mothers but not the "donors" of the

ova or embryos would create avenues for evasion of the legislation. To achieve a consistent policy position and to safeguard the family security of all children born in Ontario, "reproductive contract" must be given wide meaning to include all forms of arrangement that might be devised to evade the usual understanding of "surrogacy."

RECOMMENDATION 5

That the Criminal Code be amended to provide that anyone is guilty of an offense who promotes a reproductive contract or provides services toward the formation or execution of such contract for a fee; and that the amendment expressly exclude from criminal liability any biological or marital party to a purported reproductive contract.

RATIONALE

The intention behind criminalization is not to control women's reproductive choices, pregnancies, or placement of their children, but to prevent other persons from promoting or arranging reproductive contracts as brokers, middle persons, medical practitioners, or lawyers. This exemption would put the enforcement attention at the institutional level, without further criminalizing women's reproductive choices.

Council members did not reach consensus on this recommendation. A third of the Council members believed that anyone involved in the contract should be subject to criminal prosecution. They believe that exempting certain parties will not discourage people from entering into contracts and will enforce the coercion and commercialization inherent in reproductive contracts. Further, there was concern expressed that excluding these parties from criminal liability would allow people to pose as a contracting couple and later sell the baby.

However, the majority of Council members believe that if the birth mother, her partner, or a donor of reproductive material used in a reproductive contract are exposed to criminal liability, then the threat of criminal investigation could well be

used to influence the decisions the birth mother might make about compliance with a purported contract. It is also possible to imagine that such threats could be made against her partner or a donor, or, in a reversal, by the birth mother against the purchasing party(ies) to the contract. In addition, every woman's pregnancy could become subject to criminal investigation, and would expose pregnant women to disproportionate enforcement activity. Neither of these effects would promote the status of women or safeguard the security of birth mothers, their families, or their children.

Reproductive contracts pose a threat to the well-being and security of women and children by reducing them to chattels in a reproductive marketplace and by surrounding reproduction with an array of medical and legal interventions that have been demonstrated to harm women and children. The most unambiguous and enforceable statement is to amend the Criminal Code as per Recommendation 5. As litigation over various aspects of these contracts continues to arise, such a statement would provide civil and criminal judges, as well as professionals, with an important guide to decision making.

RECOMMENDATION 6

That new provincial legislation be enacted to provide that lawyers, medical practitioners, and other professionals who knowingly provide services in relation to promoting or arranging a reproductive contract are engaging in unprofessional conduct and that the province amend the relevant legislation accordingly.

RATIONALE

Reproductive contracts are the creation of medical and legal professionals working together to formulate procedures and legal terms that will produce the desired result: children gestated to order. With the exception of professional issues that have been raised in Michigan regarding the activities of lawyer Noel Keane, no jurisdiction has

confronted the question of whether these activities are consistent with the ethical obligations of professionals. Ordinarily, engaging in criminal activity is unprofessional conduct, but it is unlikely for medical practitioners and lawyers to easily give up their present prerogatives in this area.

Such a provision might well cross over existing professional ethical standards, but it would place professional bodies under an active duty to review the issue and come forward with ethical guidelines consistent with the new legislation.

This provision would not affect medical practitioners, for example, who provide AI to someone who obtains it under the pretence that she intends to raise the child herself. Nor would it affect anyone who participates in prenatal care, childbirth, or postnatal care, however the child is conceived.

RECOMMENDATION 7

That the new provincial legislation declare all reproductive contracts to be null, void, and unenforceable as against public policy.

RATIONALE

One of the biggest reasons reproductive contracts are popular with infertile couples or other purchasing parties is that the uncertainties and frustrations of the adoption process are eliminated because the birth mother is placed under the control of the purchasers. This control is constructed by contract and by medical practice. Legal nullification of this control will have two effects: First, it will prevent parties to such a contract from attempting to gain enforcement of a reproductive contract without the consent of the birth mother. This will give women and contract children some protection from a life of custodial embattlement. Second, it will deter individuals and couples from making such agreements, because the risk that the birth mother might decide to refuse to surrender her child will make it a less attractive method of becoming a parent.

RECOMMENDATION 8

That the legislation recognize the birth mother's parental status as inalienable.

RATIONALE

Declaring reproductive contracts to be null and void does not, in and of itself, settle all issues of maternity, paternity, child custody, visitation, child support, and child status that would still arise. Because judges have come up with so many different positions on these issues, it is necessary to rationalize them with coherent legislation that addresses each issue.

The first and most central issue is "whose child is this?" This recommendation would ensure that no other party -- neither a sperm donor nor the donor of fertilized or unfertilized ova -- would be able to bring an action for the involuntary termination of the birth mother's parental status as part of an adoption-like process. This provision would be the cornerstone for a series of provisions that would be needed to protect the security of the child's relationship with the birth mother, and if she chooses, with her family. This and the other related provisions are designed to protect the legal status of every birth mother, preventing the creation of a class of "breeder" mothers who have a lesser connection to their children.

For maximum clarity, this provision should stipulate that no provable fact besides the fact of giving birth, can affect the status of the birth mother. This would mean that evidence a woman was engaged in a reproductive contract, or became pregnant through the use of donated reproductive material, or performed any or all of the terms of a purported contract, or received part or full payment under the terms of a purported contract, would go only to establishing that she is the birth mother, but could not be used to defeat her status. Such elaboration would protect the child(ren)'s legal connection to the birth mother without regard to the details of the pregnancy or reproductive material leading to the child's birth.

This provision would make it clear that as a matter of policy, the process of carrying and birthing a child is the single most important factor in determining parentage and custody rights in the specific situation of children born as the result of reproductive contracts. This would be true whether competing claimants rely upon biological or genetic connection, payment of money, or contract expectation as the basis for their claim. However, it is intended to go only so far as to protect the birth mother's parental status, and will not prevent the recognition of other parents to the child, when parentage has been created by virtue of the child's actual living situation and attachments. Note that although the birth mother's parental status is inalienable, she cannot preclude her partner from also becoming a parent to the child under certain circumstances. See recommendations 9 through 12 for further elaboration on these principles of parentage.

RECOMMENDATION 9

That the legislation provide that the existence of a purported reproductive contract cannot be treated in legal proceedings as evidence of the birth mother's abilities as a parent or the best interests of the children; but can serve only as evidence that the birth mother of the child(ren) in question is the legal parent.

RATIONALE

In some parentage, custody, and visitation litigation over disputed reproductive contracts, the fact that a woman initially entered into a reproductive contract has been treated as evidence that she is not a fit mother, on the assumption that a fit mother would never enter into such an agreement.[20] This seriously misunderstands the particular motivations and strengths of women who have agreed to bear children for other people, and can turn an already traumatic legal dispute into a deep betrayal of the birth mother. It is equivalent to arguing that because a woman initially placed a child for adoption, she is not a fit mother. This supposition substitutes for a careful appraisal of actual fitness, prejudices which may not have any application to a particular birth mother.

RECOMMENDATION 10

That the birth mother may take affirmative steps to cause her partner to be recognized as the other legal parent of the child.

RATIONALE

The birth mother's parental status is inalienable no matter how or why she has become the birth mother. If such birth mothers chose to raise their children as single women, that is a perfectly valid choice. However, some birth mothers are in long term, committed relationships at the time of birth, and may wish to form a family unit with that partner and the newborn child(ren). Under those circumstances, maternal autonomy is best respected by ensuring that birth mothers have legal authority to have such social parents recognized legally. At present, birth mothers do have this authority under Ontario law. However, there is no single legal provision that clearly sets this out, and the security of birth mothers and their families would be safeguarded by such a provision.

"Affirmative acts" which cause the partner of a birth mother to be recognized as a legal parent to a child could include some of the following actions: placing the partner's name on the birth registration form as "father"; giving the child(ren) the partner's name or names; executing documents which confer parental authority on the partner (inter vivos guardianships, durable powers of attorney, testamentary guardianships); teaching the child(ren) to refer to the partner as "mother" or "father"; referring to the affectional unit as a "family"; naming the partner as parent of the child(ren) in official documents (such as school registration forms, tax returns, etc.); and the partner care and control of the child(ren) consistent with parenting.

Evidence that the birth mother has taken such affirmative steps should be treated as establishing a rebuttable presumption that the partner is the other legal parent of the child(ren) in question. These affirmative acts should be taken as expanding the definition of "parent" in child welfare legislation, not as constraining it.

The presumption established by these affirmative acts can be rebutted under only two circumstances: (1) when there is evidence that the partner has not consented to living as the parent of the child(ren) and has not exhibited a settled intention to act in the role as parent to the child(ren) in question; (2) when there is evidence that the partner had coerced or induced the birth mother to engage in such affirmative acts as the result of his/her violence, whether that violence has been directed at the birth mother or at the child(ren), and whether such violence has taken the form of actual completed battery, with or without detectable physical injury; assaultive behaviour; sexual assault; violence against animals or property; psychological abuse; or financial control.

For the purposes of this provision, "partner" should be defined expansively to reflect the realities of actual family composition. The adult cohabitant of a birth mother should be considered to be her partner without regard to whether that partner has contributed any reproductive material to the creation of the child and without regard to the marital status, sex, race, age, physical or mental ability, or economic status of that partner.

This recommendation is consistent with Ontario child welfare legislation, which defines "parent" expansively as anyone who has consistently over a substantial period of time has demonstrated a settled intention to act as parent to a child.[21] A provision like this is necessary because numerous birth mothers who became pregnant by AI, IVF, whether within a cohabitation or a reproductive contract, have attempted to raise lack of biological connection between their former partners and their children as a way to terminate their partners parental status even when those partners had assumed the role of parent from birth. Similarly, nonbiological partners have based a refusal to pay child support after relationship termination on the lack of biological connection. Both of these kinds of positions detract from the security of children born as the result of reproductive contracts, because they would otherwise be treated as de facto illegitimate children and deprived of important parental connections and support.

RECOMMENDATION 11

That the legislation include a provision that a donor of sperm, ova, or embryos, or a party to a purported reproductive contract, cannot apply for a declaration of paternity or maternity of a resulting child, nor be considered to be a parent to the resulting child merely on the basis of biological/genetic connection, contractual expectations, or performance of contract.

RATIONALE

This provision would complement the recognition of the birth mother's inalienable parental status, and would ensure that the donation of reproductive material would not, by itself, form a sufficient basis for a legal proceeding for parentage by anyone else.

This provision would continue to be limited by the definition of "parent" in Ontario child welfare legislation, which currently defines "parent" as any adult who has demonstrated a settled intention to act as parent to a child. The protection for women from involuntarily co-parenting with biological donors under these circumstances, however, is that no birth mother would be under any duty to allow a donor access to her child, nor could any court order such access on the basis solely of biological or genetic donation. The definition of "parent" in child welfare legislation applies only when there is an established history of actual parenting, and the birth mother would have full control over whether a donor does become involved as a parent.

For example, if a "co-parent" sperm donor actually lives in another province and sees the child only once a year for a weekend, he would not be considered to be a "parent" under existing Ontario law. However, a co-parent who has part-time residential custody of the child by arrangement with the birth mother might be recognized as a parent. In situations in which the donor is also a cohabitant, recommendation 10 above would apply. However, in situations in which the brother

of an abusive man donates sperm to the abuser's wife, for example, the fact of violence and duress would override evidence of affirmative acts recognizing the brother as a parent.

RECOMMENDATION 12

That the parentage provisions in recommendations seven through 11 apply for all legal purposes, including but not limited to: adoption; intestate or testate succession; support, custody, access, or visitation; probate law exemptions, allowances, or other protections for children in parent's estates; social benefits; next-of-kin provisions; and donative transfers to children as a class.

RATIONALE

The parent-child relationship has implications for almost every aspect of the child's life -- implications beyond physical custody and care. Without conducting a detailed survey of all Canadian and provincial laws, it would be difficult to list all implications. A declaratory provision like this should be open-ended, and state the principle that will help resolve novel issues: once a parent-child relationship has been established in law, it can be terminated only through formal adoption proceedings, and will be considered to be dispositive of every situation in which legal results depend upon the existence of a parent-child relationship. This would cover every situation, from defining eligibility for OHIP coverage, for example, to defining "child" for purposes of inheritance or immigration purposes.

RECOMMENDATION 13

That the legislation should provide that the birth mother may bring an action for damages or an injunction, including costs of the action, in the following circumstances:

(a) against any person who attempts to enforce a reproductive contract, or who seeks a declaration of paternity or maternity on the basis of

donated reproductive material, or who seeks adoption, custody, or visitation through the legal process, merely on the basis of donated gametes, in proceedings contested by the birth mother;

(b) against any person who seeks to waive the birth mother's right to consent to adoption, unless such waiver is sought in the context of care and protection proceedings;

(c) against any person who seeks to exercise surveillance over a woman's health or medical practices during conception, pregnancy, labour, childbirth, or lactation, whether on the basis of a reproductive contract or other arrangements;

(d) against any person who solicits or requests a woman to engage in a reproductive contract, including her partner or any other member of her family;

RATIONALE

Numerous harms are caused to women and children by reproductive contracts. Some harms, such as the commodification of reproduction and children, occur because they fundamentally deny the personhood and autonomous needs of women and children. Other harms are caused by the fact that women and children hold very little power in mainstream institutions, and are almost always victimized by contested custody and adoption proceedings. A third set of harms arises when women have to bear the physical, emotional and financial costs of reproductive contracts. This provision would redress these imbalances by identifying the circumstances in which women can bring actions for money damages. While most of these actions could be sustained by extending basic principles of civil liability to the situations of embattled birth mothers, access to justice demands that these rights of action be provided in a coherent body of legislation.

The existence of these rights of action is not to be taken in any way as rendering reproductive contracts enforceable.

RECOMMENDATION 14

That the legislation should provide that birth mothers are not liable in relation to the following matters:

(a) any actions for the refund of any money that may have been paid either as fees or as expenses in relation to a purported reproductive contract;

(b) any actions for failure to perform an undertaking under a purported reproductive contract, frustration of contract, or similar action, whether the remedy sought is specific performance or money damages.

RATIONALE

This immunity is necessary to complement the other recommendations in this brief. Aside from criminal penalties for promoting or arranging a reproductive contract, the main disincentive to solicit women for their reproductive services proposed in these recommendations is the declaration that such contracts are null and void, and do not displace the birth mother and her partner's parental status. By ensuring that a birth mother cannot be sued for nonperformance or for return of any monies paid under a purported contract, the risk of nonperformance is almost entirely on the other party(ies), not on the birth mother. This further counters the vulnerabilities of women in relation to reproductive contracts.

ALTERNATIVE INSEMINATION

Sperm donation and alternative insemination are noninvasive, low-risk procedures which meet the fertility needs of a diverse population: women who are in a relationship with men who have impaired fertility or a genetically transmitted condition; single women who wish to conceive without sexual intercourse; lesbian women who wish to have children with or without a partner. The "technology" associated with alternative insemination is easy to use, cheap, and versatile, making decentralized and nonspecialist use easily available. This technology is well developed and the social-legal problems consequent to alternative insemination are relatively easy to resolve.

Alternative insemination itself poses no discernable harms to women and children. Indeed, the only harms that could be considered to arise out of this "technology" are those caused by conflicts over the children who are born through AI, the restricted access to AI that is enforced by the medical profession, and the use of invasive, medically risky or pharmacological procedures to enhance women's fertility in conjunction with AI. These recommendations focus on addressing the harms of these procedures, ensuring widespread access to safe AI, and securing parentage in their birth families for children conceived through AI.

RECOMMENDATION 15

That new legislation be enacted which guarantees access to alternative insemination to all adult women as a matter of choice and not subject to discrimination[22] by virtue of unproven fertility, marital status, reproductive history, physical or mental disability, race, sexual orientation, age, or economic condition.

RATIONALE

Studies have shown that approximately 50% of all women who seek medical assistance in becoming pregnant do so because their male partners are infertile in some degree. An unknown additional number seek medical or private AI because they have no male partner but seek to have a child. AI has both the highest success rate of all the "technologies" and is the safest, least invasive procedure. Yet access to AI is constricted both by medical practice and by the lack of information surrounding private AI. Almost all medical practitioners require a woman to undergo invasive, risky, and damaging fertility investigations like hysterosalpinograms and laparoscopies before they will make AI available to the women they do agree to treat. A substantial number of practitioners also resort to strong fertility drugs like clomid, progesterone, and others if the first few inseminations do not result in pregnancy. These procedures and drugs can and frequently do result in impaired fertility or even medically-induced menopause in women who are still in their 20s or 30s. In addition, medical practitioners routinely refuse to perform AI on women who are not married, even if they are in a stable relationship with a man or a woman, or who are not, in the opinion of the practitioner, young enough or sufficiently well off or require a sperm donor from a particular racial group or already have enough children or who are unlikely to get pregnant "soon enough."

The experience of discrimination in the very personal and vulnerable area of reproduction is especially damaging to women, and medical practitioners should be legally prohibited from so discriminating. If a medical practitioner does not feel comfortable offering AI to every adult woman in his/her practice, then that practitioner should be prohibited from practising in that area. In particular, medical practitioners should be prohibited from disguising discrimination as "medical necessity."

RECOMMENDATION 16

That the Ontario Human Rights Code (OHRC) be amended to provide that a medical practitioner who discriminates on the basis of unproven fertility, marital status, physical or mental disability, race, sexual orientation, age, or economic condition in relation to access to AI has engaged in discrimination on the basis of sex, sexual orientation, race, or age under the OHRC, and further, that the relevant professional legislation be amended to provide that it constitutes unprofessional conduct for purposes of determining professional sanctions.

RATIONALE

This provision would offer remedies to women who experience this form of discrimination. For example, medical practitioners and clinics which use psychological screening to disguise concern over the psychological soundness or motives of single, divorced, or lesbian women would be violating human rights. There may be, however, health safety reasons for medical practitioners to deny a woman access to alternative insemination. Such factors might include age and reproductive history. Doctors should know that it is within their professional purview to exercise judgement in this regard.

RECOMMENDATION 17

That medical practitioners be prohibited from using fertility drugs in conjunction with AI unless they are unquestionably necessary and the woman receives full, timely, and understandable information on the experimental nature and the "side effects" of these drugs.

RATIONALE

In addition to the liberal use of fertility drugs to boost women's fertility in conjunction with AI, many medical practitioners use such drugs on women who have apparently intact fertility in order to time ovulation conveniently. This unnecessary use of strong drugs should be prohibited.

When drugs like clomid and progesterone are used, the medical practitioner should give the woman full information on all the effects that such drugs may have on her health and her future fertility, and obtain her informed consent to their use. The burden of restraint and disclosure on the practitioner in such circumstances must be very high, since infertility often creates a desperate state of mind in which serious risks are gladly taken.

RECOMMENDATION 18

That new legislation provide for access to banked sperm and sperm testing services for all adult women, whether or not they are using the services of a medical practitioner.

RATIONALE

Sperm banks are already licensed and regulated by existing legislation. Mass technology can already test sperm for transmissible diseases, adequacy and motility. The technology for transporting frozen tested sperm is low cost and easy to use. Sperm samples can be shipped and stored virtually anywhere in low cost nitrogen tanks, and the procedure for self insemination is quite simple for women to perform on themselves. Women who prefer to use unfrozen sperm samples, donated privately or through a medical practitioner, should have access to low cost and nondiscriminatory services to evaluate the safety and fertility of the sperm. They should also be able to have some of those samples stored by a sperm bank for them if they so chose.

These goals would best be achieved by making banked frozen sperm and sperm testing services available to all women. Such access would ensure that women can use banked sperm from HIV-negative donors.

RECOMMENDATION 19

That sperm testing protocols be developed to ensure that carriers of sexually and other genetically transmitted diseases do not transmit them in sperm samples.

RATIONALE

Effective screening for AIDs requires that sperm samples be kept frozen until follow-up screening can be carried out six months after the sample has been taken to ensure that the donor is not HIV positive. All banked sperm should be subject to this procedure. Each sample should be screened for STDs in relation to each donor, and recipients of

sperm samples that have not been or cannot be screened for STDs should receive this information. Sperm testing for AIDs and STDs should be conducted only with the donor's consent.

RECOMMENDATION 20

That the new legislation provide that "medical practitioner" include licensed midwives[23].

RATIONALE

Midwives who provide alternative insemination are generally far less discriminatory in the services they provide than are medical practitioners. However, increasing pressure on midwives to conform to medical norms and practices is resulting in constrained access to AI even through midwives. This provision would ensure that both medical practitioners and licensed midwives are under a duty to provide AI to the women in their practices as a matter of the woman's choice.

RECOMMENDATION 21

That all fertility services related to alternative insemination, including the actual insemination as well as all the allied procedures (collection, testing, freezing, and transportation of sperm; any diagnostic procedures that might be required; etc.) be fully covered medical services under the Ontario Health Insurance Plan, without discrimination by geographic location, marital or reproductive status, sexual orientation, race, age, physical or mental disability, or economic condition.

RATIONALE

Although these forms of reproductive "technology" are low cost, relative to others like IVF, they are still moderately expensive. Even when private donors provide sperm samples directly to the office of the medical practitioner who may be performing an insemination, there are still costs associated with the testing of the sperm and the office visit. When frozen sperm is used, samples may cost over $100, depending on what source is used. All these costs should be covered under OHIP, on a nondiscriminatory basis. OHIP regulations aimed at limiting the number of years that a woman may continue trying to conceive, however, may be reasonable if they are not a proxy for other access criteria.

RECOMMENDATION 22

That the new legislation recognize the legality of private alternative insemination arranged between consenting adults.

RATIONALE

The decision by a man to donate sperm to a woman remains an individual choice which should be beyond the reach of government regulation. And the decision by a woman to become pregnant, even through private donation of sperm by an identified or unidentified male, remains an individual choice which should be beyond the reach of government regulation. Even though some aspects of private donation may involve the services of medical practitioners or midwives -- for example, testing the

motility of the donated sperm or obtaining a sperm count -- individuals should still have the option to make all other arrangements privately.

Ordinarily, women will find it more convenient to have a medical practitioner or a midwife act as intermediary, but those services may not always be available. Availability should not be the determining factor in access.

It has been asserted by the Ontario Law Reform Commission that private insemination is too risky to be permitted in Ontario, with women being exposed to the risk of serious injury, even death.[24] This statement is unfounded and is not based on any reported cases. On the contrary, the method women use in self-insemination is safer and has fewer side effects than medical insemination. Medical practitioners inject sperm samples directly into women's sensitive and delicate cervix; this frequently causes cramps, pain, discomfort, and bleeding. Home insemination, however, is done with noninvasive instruments that place the sample in the woman's vagina, far from her cervix.

RECOMMENDATION 23

That new legislation be enacted to provide that except for children conceived by alternative insemination and born to women living as single women at the time of birth, the parents of the child shall consist of the birth mother and her partner, whether they are married or unmarried, and whether they are of the opposite sex or of the same sex, if the birth mother has performed one or more affirmative acts after the birth of the child to cause her partner to be recognized as a legal parent of the child(ren). (A detailed description of affirmative acts is found in the rationale of Recommendation 10).

RATIONALE

This provision would ensure the security of the family situation of AI children at the same time that it recognizes the primacy of the birth mother's relationship with the child(ren). As women who have conceived by AI have entered into custody,

visitation, and support disputes with partners who have been parents of the AI children from birth, it is becoming apparent that either party, in the bitterness that frequently attends family breakdown, may be willing to deny the parenthood of the nonbiological partner to gain an advantage in litigation.[25] This type of tactic increases the stress of litigation and the risk to children involved in custody conflicts that they may be cut off from their nonbiological parent.[26] The detailed criteria in recommendation 10 would make this determination more principled, and hopefully restrict the scope of such custody conflicts to a determination of the child(ren)'s needs, and not open it up to issues of biological/nonbiological connections.

RECOMMENDATION 24

That the new legislation should provide that the sperm donor is not a parent to any resulting AI child, whether "paternity" can be established or not, and that no sperm donor may bring an application for the determination of paternity, or for custody or visitation, or is liable for support, on the mere basis of having donated sperm.

RATIONALE

This provision would complement recommendation 23 in protecting the family security of AI children and give maternal autonomy wide scope. If the birth mother enters into a course of conduct that results in the creation of a parental relationship between the sperm donor and the child, custody, visitation, support, and inheritance are possibilities under Ontario's welfare legislation or under Recommendation 10. In the absence of such conduct, the sperm donor should remain a stranger to the child and her/his birth mother.

RECOMMENDATION 25

That the new legislation provide that no one can become a parent to an AI child merely by virtue of performing insemination as a medical practitioner, midwife, friend, or relative, but that evidence that the birth mother's partner has performed or participated in the AI process can be admitted as relevant to establishing the birth mother's intention to involve her partner in a parental capacity.

RATIONALE

One of the reasons many medical practitioners have given for refusing to perform alternative insemination on single women is their fear that they will be sued later for paternity or child support by the single woman, and that the AI children might bring an action for a share of their estates by inheritance. Although this fear is completely groundless in law, it has wide currency and should be eliminated by specific legislative

provisions. However, it should be framed so that a cohabiting partner who performed inseminations on the birth mother can rely on that fact in showing an intention for both adults to live as parents with the resulting child.

RECOMMENDATION 26

That new legislation provide that the birth mother of an AI child may register both herself and her partner, whether married or unmarried, and whether of the same or the opposite sex, as parents of the child. Consent of her partner is required only if she is unmarried.

RATIONALE

Many women who have borne AI children have felt compelled to register the child as sole parent or have resorted to misrepresentation to register their married, unmarried, or same sex partners as the "father" of the child. When birth mothers

intend at the time of birth to live as co-parents of AI children, they should be able to document that intention in the birth registration process without ambiguity or misrepresentation.

The requirement that unmarried partners have the right to consent to such registration is consistent with existing birth registration rules. Under present law, if married, the partner is deemed to the "father" by virtue of marriage, but assumption of that status by non married partners is considered to be voluntary.

RECOMMENDATION 27

That the regulations governing sperm banks be amended to provide for the creation of databases to link donor, recipient, and birth information for purposes only of making genetic and health information available to children born as the result of AI, and that such records be kept for a minimum of 100 years.

RATIONALE

This provision would ensure that computer technology can be used to document the genetic and biological links that are sometimes important to the diagnosis and treatment of certain conditions. The health implications of sperm donation have not yet been fully explored, and erring on the side of caution seems preferable. Ideally, sperm donors should be requested to update sperm banks with information that subsequently becomes available, but, admittedly, this would be an admittedly unwieldy amount of information to manage. However, it would be important to ensure the confidentiality of this information so that it cannot be accessed to satisfy inappropriate interests in the biological origins of particular children.

RECOMMENDATION 28

That new legislation secure the confidentiality of sperm donors by providing that the identity of the sperm donor(s) or recipients cannot be disclosed to the child as per current Ontario Adoption Laws.

RATIONALE

This provision would further ensure that sperm donors remain strangers to the families of AI children, that AI children remain strangers to the families of sperm donors, and that judges would be able to require quite compelling reasons to break either aspect of donor-recipient confidentiality. However, this provision would not interfere with the transmission of genetic or medical information on the donor to the child(ren) or their mothers, to be used for medical purposes.

RECOMMENDATION 29

That legislation and regulations relating to the licensing and operation of sperm banks be amended to provide for the provision of two levels of confidentiality: absolute confidentiality, as described in recommendation 28 above, and conditional confidentiality, where donors have elected to allow their identity to be disclosed to any resulting children after they are 18 years of age.

RATIONALE

Some birth mothers would like to tell their AI children that they can obtain information about their donor after the children reach the age of 18. No children who have been conceived with sperm donated by men who have elected conditional confidentiality have yet become 18 years old (the oldest are about 12 years old right now), so there is no empirical basis to prohibit this option.

FERTILIZATION TECHNOLOGIES

"In vitro fertilization" is just one of several forms of technological fertilization currently being developed. During in vitro fertilization, several eggs are removed from a woman's ovaries, and fertilized with sperm in a laboratory, usually in a petri dish. The fertilized eggs are then placed in the woman's uterus. To ensure the maximum number of eggs is produced, women involved in IVF are usually prescribed high dosages of fertility drugs like Clomid. The long range effects of these drugs are unknown.

The success rates for IVF are quite low. For example, World Health Organization studies show that up to 90% of women who undergo IVF do **not** go home with a baby. Furthermore, when IVF clinics talk about their success rate, they often refer to the number of pregnancies achieved and not the actual number of babies born.

The costs of this technology are quite high. Ontario is the only province to cover IVF in hospital-based clinics. The waiting period in hospital-based IVF clinics can be up to 2 1/2 years. Couples who go to private clinics in Ontario or to others outside Ontario, can pay from $1,200 to $5,200 per procedure.

The Advisory Council is strongly of the opinion that in vitro fertilization is a misallocation of important financial and human resources. While we recognize the anguish and frustration that infertile women face in their attempts to have a baby, we believe that IVF does not address the problem of infertility, it simply bypasses it. IVF has a low success rate, it's harmful to women, and in many cases, children are born prematurely. Infertile women would better be served if funds were allocated to research more thoroughly the causes of infertility and to look more aggressively for cures. More research money needs to be directed toward further understanding the causes of infertility, so that the problem can be approached collectively through preventative measures rather than individually through hi-tech measures.

The high costs of IVF deplete health care resources that should be available to everyone in Ontario. Public funds used up by IVF far outweigh those set aside for research into the growing causes of infertility. Many infertility problems that bring women to seek IVF are caused by other health problems, including sexually transmissible diseases and infertility drugs themselves, yet the allocation of resources to research infertility remain tiny. While the emotional appeal of biological reproduction remains strong, it is difficult to justify the use of IVF when the visible costs can run up to a minimum of $10,000 per attempted conception and the costs of developing and maintaining this technology are similarly high.

In northern and rural areas of Ontario, access to health and natal care services is inadequate and often unavailable. In northwestern Ontario, for example, birthing services are limited and women must travel long distances away from home to give birth. This situation places added stress on the mother, baby and family. Public health care is expensive and questions of how the money is allocated and where it goes in the system should be considered in light of the tremendous costs and low success rates of IVF.

Thus the Advisory Council is of the opinion that budgetary expenditures on health and natal care in northern and rural communities, and on infertility research should be increased substantially while IVF spending should be reduced accordingly. It is estimated that 20% of female infertility is due to factors that can be addressed by IVF; the success rate of IVF is minuscule in comparison with the costs; the technology and drugs used in IVF are dangerous and invasive, and the women on whom they are used are subject to tremendous social pressure to become biological mothers, despite mounting evidence of IVF risks.

Nonetheless, the Council is of the opinion that governments should declare a moratorium on funding fertilization clinics until it can be demonstrated that there are safer and more effective ways of achieving fertilization. In addition, the Council recommends that women who do participate in such experimental fertilization

techniques during the moratorium should be given full disclosure of the risks involved and should be insured by the clinics against injuries caused by medical or drug treatment. Many people have a strong drive to reproduce biologically, and mere "informed consent" to the risks of fertilization procedures and drugs is not an adequate safeguard.

Since some children in Canada have already been conceived by IVF, while others so conceived may come to live in Canada, the Advisory Council is making recommendations on the issue of family security along with its recommendation for a moratorium.

RECOMMENDATION 30

That provincial governments should impose a moratorium on the use of fertilization techniques, except for experimental purposes; that a special committee be appointed to conduct a public review on the results of these experiments and the risk levels of the medical and drug therapies involved to determine acceptable levels; and that this committee be made up of feminists, medical personnel, lawyers and lay persons.

RATIONALE

Fertilization techniques are in fact experimental, but media enthusiasm and popular demand have obscured both the high levels of risk and injury associated with them and their low success rates. If general funding and OHIP coverage are withdrawn during a moratorium period, and if these techniques are conducted in frankly experimental settings, then the level of enthusiasm is likely to become more realistic in light of risks and failure rate. Perhaps more importantly, women and their reproductive capacities will be treated with more respect.

Until experimental results are available to guide policy makers, the funding that is withdrawn from fertilization clinics can be redirected to the provision of enhanced

health and other care for women and children in the north and rural areas and for children in care. This reallocation would put resources to work to support children who already exist, and for whom all Canadians are collectively responsible.

Women have not usually been involved in the review process of medical practices. However, it is essential that women be included because these processes and technologies affect them in the most fundamental and intimate way.

RECOMMENDATION 31

That new legislation should prohibit the use of human gametes for any procedure other than alternative insemination, whether by a laboratory technician or a medical practitioner, with the intention of achieving pregnancy, unless the institution within which the procedure is carried out takes full responsibility for fully disclosing all the physical and psychological risks of the procedure(s) to the women involved, and for any harm that may occur immediately or at any point in the future to the women involved or to their resulting children.

RATIONALE

This provision would bring an end to the various forms of egg collection, IVF, and other techniques that are being used experimentally and in medical practice to achieve assisted conception, except within the stringent context of experimentation on human subjects. These ethical constraints require a high level of disclosure to human subjects, as well as institutional review of the probable effect of the experimentation on the human subjects and regular reporting.

The additional requirement that institutions become the insurers of their subjects, with no statute of limitations, puts the full risk on them instead of on the women and children who are historically disadvantaged both in getting information on these kinds of risks and in obtaining damages for actual harm in subsequent legal proceedings.

RECOMMENDATION 32

That banking of human embryos be prohibited; that human ova be cryopreserved only for individual women, and not be made the subject of donations or commercial traffic; that the practice of hormonal stimulation to produce multiple ova during each menstrual cycle be prohibited.

RATIONALE

These recommendations set limits on the fragmentation of motherhood that is implicit in fertilization technologies. Human embryos, which have the potential to develop into human fetuses, should not be the subject matter of experimentation, cryopreservation, donation, sale, or other commerce. Human ova, which must be fertilized before they have the potential to develop into human fetuses, are and should remain within the control of the woman whose body produced them, and should not be available as commercial, donative, or experimental objects.

Human ova are not the same as human sperm. Women produce a fairly small number of ova during their lives; removal of ova requires heavy drug and surgical intervention. These interventions create substantial risks of harm to women, and should not be performed unless the woman whose ova are being removed for fertilization is the woman who will become pregnant with the resulting embryo.

One of the biggest sources of drug injury to women in fertilization programs is the effect on the ovaries of hormonal stimulation and hyperovulation. Supernumerary ova cause other complicating problems too: implantation of all fertilized ova leads to multiple pregnancies, which are more risky that single pregnancies, and also lead to demand for selective pregnancy reduction, itself an additional source of risk; cryopreservation of supernumerary embryos leads to uncertainty about the "ownership" and control over that material, and creates opportunities for commercial markets, experimentation with human embryos, and pressure on women to "donate" these embryos to medical researchers.

RECOMMENDATION 33

That existing cryopreserved ova and embryos be treated as the sole responsibility of the woman who contributed them, should any dispute over their control or disposition develop, and, where the donor woman cannot be identified with reasonable certainty, they may not be used in any medical or research procedure but should be destroyed.

RATIONALE

This recommendation is necessary because there is at least one ovum bank in Canada, and doubtless other ova or embryos are cryopreserved across the country. Destroying the ova or embryos will ensure against any unauthorized research.

RECOMMENDATION 34

That frozen embryos in any stage of development or division are not juridical persons, have no rights under any law of Canada, and have none of the incidents of legal personality.

RATIONALE

This provision will make it clear that frozen embryos, even though they may have the potential to develop into human fetuses if they are successfully implanted, do not have any legal incidents of personhood. This recommendation addresses the pressures, in some jurisdictions, to extending the concept of life before birth to include the very first cellular divisions following fertilization.

RECOMMENDATION 35

That a special committee be appointed to develop monitoring protocols of women and children who have been affected by fertilization techniques, to collect information on the short-term and long-term effects of those procedures and drugs, and to inform women of these findings; and this committee be made up of feminists, medical personnel, lawyers and lay persons

RATIONALE

To date, medical practitioners have operated more or less independently in identifying the risks associated with IVF, in performing follow-up, and in informing women of risks.

RECOMMENDATION 36

That new legislation be enacted to secure the parentage of children born as the result of IVF, with the birth mother to be recognized as the only legal parent of such child, unless she takes affirmative steps to cause her partner at the time the child is born to be recognized as the other legal parent (consent of her partner is required only if she is unmarried). Under this legislation, no person, merely by virtue of donating sperm, ova, or embryos, accedes to the status of parent.

RATIONALE

As with other forms of reproductive arrangements, fertilization techniques have blurred the definition of "parent," "mother," and "father," raising questions in some minds as to the effect of donated ova, sperm, or embryos on the determination of parentage. Consistent with the other recommendations made by the Advisory Council on this point, the birth mother and her partner, whether married or unmarried, and whether of the same sex or the opposite sex, should be recognized as the only legal parents of IVF children, with the birth mother holding, at the time of the child's birth, the right to determine whether her partner is to be recognized as a parent too. To do otherwise, or to confer legal parentage on three or four adults altogether, would be to unnecessarily expose IVF children to the risk of living fragmented and conflict-ridden lives from birth. (see recommendation 10).

RECOMMENDATION 37

That new legislation be adopted which provides women and children with an action for damages caused by any procedure or drug used in attempting or achieving pregnancy by in vitro fertilization, whether or not that woman has signed a consent to the procedure or drug; and even if that woman has, on her own behalf or on behalf of such child, waived any action for damages in writing or otherwise.

RATIONALE

This provision ensures that the routine use of extensive or blanket consent and waiver forms in fertilization clinics will not prejudice women and children, most of whom have been involved in experimental techniques, in future actions for damages. The kinds of harms caused by IVF-associated drugs and techniques are not all known. The harms of many experimental items sometimes are not disclosed for years afterward.

Here is a list of some harms that could be the subject matter of an action for damages under this recommendation: fertility affected by use of fertility drugs; unconsented removal of woman's ova for experimental use or to create embryos for storage or to be used in someone else's pregnancy; pelvic infection caused by lavage; injuries caused by introducing foreign human tissue into women's bodies; ectopic pregnancy caused by unsuccessful lavage or embryo transfer; hyperstimulation of ovaries in hormone manipulation; trauma to ovaries during removal of ova; injuries caused by single or repeated anaesthetization; damage to uterus or cervix in embryo transfers; injuries caused by selective abortion or multiple births; harms to female fetuses by IVF drugs.

The Council is also making recommendations on the liability of medical practitioners and scientific researchers for the harms caused to women and children by IVF procedures and drugs, since those harms will not necessarily be fully disclosed until some years after IVF has actually been attempted or carried out.

RECOMMENDATION 38

Recognizing that access to fertilization technologies will be significantly curtailed, accessibility should be determined according to need, and those women who most likely would not be considered qualified to adopt children (disabled, single, lesbian and older women, and women with the most serious fertility impairments) should receive priority.

RATIONALE

Council is not suggesting that women who are single, disabled, lesbian, older or have serious fertility impairments are ideal subjects for the experimental phase. On the contrary, we are recognizing that a moratorium will in all likelihood obliterate any chance for these women to become mothers. If fertilization technologies are to be allocated rationally, it must be according to a principle like need -- not the likelihood of easy success. Women who are unlikely to become mothers in any other way ought to receive priority, or the allocation of fertilization technologies will simply replicate the status quo. If there is any social rationale for further development or use of these technologies, it is to deal with the most intractable infertility situations.

CONCLUSION

Clearly, the legislative, regulatory, and professional standards that are needed to safeguard the interests of women and children in relation to reproductive technologies will require extensive education and significantly more resources than are now allocated to reproduction issues outside of specialized laboratories and clinics. But this is as it should be, for human reproduction and human children should not become commodities in a market place that is increasingly out of touch with the human values that are involved.

In 1988/89, more than $3,200,000.00 of the Ontario health care budget was allocated to funding IVF and other technologies, while approximately $300,000.00 was allocated to research the causes of infertility[1]. In an economy with unlimited resources, funding for embryo production and manipulation might well be desirable, if all other human problems had already been solved. But with children still suffering from malnutrition and women still not being able to obtain adequate health care, this seems like an unjustifiable luxury.

In contrast with the large amount of funding and human energy going into IVF-associated techniques, the family status of children born through reproductive contracts, alternative insemination, and IVF conceptions is in limbo, making family disruptions even more damaging for them and relegating them to second-class status.

We are convinced that our recommendations focus reproduction where it belongs: in priorizing the health and security needs of birth mothers, their children, and birth families, and in discouraging the use of contracts or technologies that commodify women or children. We recognize that our recommendations are not by any means all-encompassing, but we are hopeful that they will provide the spark for meaningful legal policy.

In addition, we strongly urge the Royal Commission to build in a discussion phase of its report before final presentation to the government. Such a "discussion" report should be circulated, inviting feedback with the intention of considering these comments in preparation of the Commission's final government report. Many women's groups felt unable to make thorough presentations due to either time constraints or lack of expertise within their membership. The "discussion" phase would give women the opportunity to examine issues about which they may not have been able to comment on previously.

APPENDIX I

POTENTIAL HARMS OF NEW REPRODUCTIVE TECHNOLOGIES

Pre-conception Contracts:

- Exploitation of poor or unemployed women by offers of payment through pre-conception contracts
- The legitimization of baby selling through pre-conception contracts
- Imposition of and disruption of family relationships
- Coerced "consent" to a wide range of risky, unnecessary procedures
- Interference with women's nutrition, exercise, sexual relations, travel, or enjoyment of other human rights
- Emotional effects upon surrender of contract child: e.g. thoughts of suicide; self-hatred; severe depression

Alternative Insemination:

- Exorbitant costs; travel costs; time required;
- Unknown risks of introducing foreign human tissue into women's bodies
- Increased rates of spontaneous abortion
- Chemically induced menopause
- Sexually transmitted diseases

In Vitro Fertilization:

- Birth defects, stillbirth, premature birth
- Failure to inform women of low success rates
- Risks associated with laparoscopy and other procedures
- Compulsory abortion in unsuccessful lavage
- Unknown risks of introducing foreign human tissue into women's bodies
- Pelvic infection caused by lavage
- Ectopic pregnancy caused by unsuccessful lavage or embryo transfer
- Effects of hyper-stimulation of ovaries in hormone manipulation
- Increased risks associated with repeated anaesthetization
- Increased risk of spontaneous abortion
- Damage to uterus or cervix in embryo transfers
- High risks of multiple pregnancies and births
- Trauma to ovaries during removal of eggs
- Damage to uterus or cervix in embryo transfer
- Higher incidence of Caesarean sections
- Chemically induced menopause

- Harm to fetus through use of in vitro drugs

- Pressure to relinquish rights to eggs

General:

- Devaluation and further stigmatization of disabled people due to the high social value of "perfect" children reflected in the development of technologies

- Encouragement of the idea that woman's primary role is to bear a child

- Effects of disruption to population balance due to worldwide preference for male children (e.g. through sex selection clinics)

- Transformation of women's reproductive capacities into saleable a item

- Reducing women to a class of breeders

- Reinforce pronatalist attitudes

GLOSSARY

The following terms were extracted form *Our Bodies... Our Babies: Women Look at New Reproductive Technologies*, produced by the Canadian Research Institute for the Advancement of Women.

AMNIOCENTESIS: A test used to diagnose genetic problems which may cause disease or disability in the fetus. In amniocentesis, ultrasound is used to guide a needle through the mother's abdomen into the amniotic sac which surrounds the fetus. A small amount of the fluid in the amniotic sac is removed and the cells are checked for abnormalities. Amniocentesis can also show the sex of the fetus. Amniocentesis is usually done in the second trimester between the 14th and 16th weeks of pregnancy. The results are not known until the 18th to 20th week. Amniocentesis has a small -- less than one percent -- chance of causing a miscarriage.

ALTERNATIVE INSEMINATION (ARTIFICIAL INSEMINATION) AI: The Ontario Advisory Council on Women's Issues has chosen to use the term "alternative insemination" as opposed to "artificial insemination out of a desire to demystify this form of insemination, and to emphasize the fact that it is not a scientific "technology", but merely an alternative methods of being inseminated.

AI is a method of becoming pregnant without having sexual intercourse. Sperm is placed in a woman's vagina when she is ovulating. There are three kind of alternative insemination: (1) AID (alternative insemination by donor), in which the sperm comes from a donor; AIH (alternative insemination by husband), in which the sperm comes from the woman's husband; and AIC (alternative insemination/combination), in which a combination of husband and donor sperm is used. Alternative insemination in North America is done with sperm from paid, anonymous donors. Because the identities of these donors are unknown to the children, it is nearly impossible for them to trace their biological father. Despite routine screening of donors, the risk of being infected with HIV (the virus which causes AIDS) is higher during alternative insemination than during intercourse with a known partner.

CHORIONIC BIOPSY or CHORIONIC VILLI SAMPLING (CVS): A test in which a catheter (small tube) is inserted through the mother's vagina and cervix, and a sample of the membrane surrounding the fetus is taken. Like amniocentesis, CVS is a test used to detect metabolic disorders and chromosomal problems. CVS can also show the sex of the fetus. CVS can be done during the eighth or ninth week of pregnancy and the results are usually known within a week. CVS has about a one percent chance of causing a miscarriage.

CHROMOSOMES, DNA, GENES and GENOME: **Genome** is the word used to describe the complete set of instructions for making a human being. These instructions are contained in the 46 **chromosomes** which humans normally have. Twenty-three chromosomes come from a mother's egg, 23 from a father's sperm. Contained in each of these chromosomes is a long, twisted ribbon of **DNA** (deoxyribonucleic acid). **Genes** - the basic biological units of heredity -- are located at specific points along this ribbon of DNA. Each gene contributes a specific bit of the information that makes each human different. The human genome contains about 100,000 genes.

CLOMID: A drug used to induce ovulation so that eggs can be collected for use during in vitro fertilization. Clomid is chemically similar to DES (di-ethyl stibestrol), a drug that has been linked to higher rates of certain cancers in the children of women who were given it. To date, there have been no animal studies or good clinical analyses of the long-term effects of clomid.

CLONING: A form of asexual reproduction in which the nucleus of a single cell is used to produce an exact copy of the original organism.

CONCEPTUS, EMBRYO and FETUS: After the egg has been fertilized, the cells begin to divide. Cells will become the "**embryo**", the term applied to the first eight weeks of development. Other cells will become part of the membranes that nourish the developing embryo. "**Conceptus**" is the term used to describe the product of conception and includes both the embryo and the membranes. After eight weeks, the "embryo" is referred to as the "**fetus**".

ECTOGENESIS: Describes the production of a real "test-tube baby." Ectogenesis means developing a human fetus completely outside the womb, using an artificial womb or life support technology. So far, this has not been done and is still only a theoretical possibility.

ECTOPIC PREGNANCY: A pregnancy that develops outside the uterus, for example in the fallopian tubes. Ectopic pregnancy occurs in one of four in vitro fertilization pregnancies, compared to one in 100 to 300 naturally occurring pregnancies. Most ectopic pregnancies end in miscarriage because tissues other than the uterus cannot support a fetus. A medical emergency, such as bleeding, can result when an ectopic pregnancy ruptures.

EMBRYO TRANSFER: A surgical procedure in which a fertilized egg is removed from one woman's uterus and placed in another woman's uterus.

EUGENICS: The term applied to efforts to "improve" the human race, either through selective breeding or genetic manipulation.

FETAL HEART MONITORING: Used during labour to detect fetal stress so that, if needed, a rapid delivery can be performed. Fetal monitoring can be done externally by placing electrodes on the mother's abdomen, or internally, by attaching electrodes to the fetus.

GENETIC MANIPULATION: Making changes in the genetic code to correct imperfections or introduce a new genetic characteristic.

GENETIC OR BIOLOGICAL FATHER: The man whose sperm fertilizes an egg.

GENETIC OR BIOLOGICAL MOTHER: The woman whose egg is fertilized.

GESTATIONAL OR UTERINE MOTHER: The woman who carries the pregnancy to term.

INFERTILITY: Inability to become pregnant as readily as most women or couples. In North America, a couple that has been having intercourse for one year, isn't using any form of birth control, and hasn't conceived, is considered by medical experts to be infertile.

IN VITRO FERTILIZATION: The fertilization of a human egg outside of the womb. The eggs are removed from a woman's ovaries, fertilized with sperm in a laboratory, and placed in a woman's uterus. The fertilized eggs may be placed either in the uterus of the woman who produced the eggs or in the uterus of another woman.

PARTHENOGENESIS: A type of asexual reproduction in which the female egg is duplicated without being fertilized by sperm. Parthenogenesis produces only female offspring. The process has been used in laboratory experiments, but has not been done with humans.

PELVIC INFLAMMATORY DISEASE (PID): An infection of the uterus and fallopian tubes. PID is often caused by untreated sexually transmitted diseases such as chlamydia and gonorrhoea. PID can cause scarring and blocking of the fallopian tubes and can lead to infertility, ectopic pregnancy or pelvic pain.

PRE-CONCEPTION CONTRACTS: The contract a woman signs when she agrees to act as a "surrogate mother" and carry a child for someone else. Under the terms of the contract, the woman -- who besides being the uterine mother, may also be the genetic mother -- agrees to give up all rights to the child she carries.

SEX SELECTION: Choosing the sex of a child before birth. Sex selection can be done before conception, by separating the male and female sperm. The women is then artificially inseminated with sperm that are likely to produce a baby of the desired sex. The most effective and commonly used form of sex selection is done after conception. Screening techniques such as amniocentesis are used to determine the sex of the fetus, and if the fetus is not the "right" sex, it is aborted.

STERILITY: Inability to conceive. Sterility may be primary, meaning that no conception has ever been possible, or secondary, which means that the sterility has been caused by surgery or disease.

SURROGATE MOTHER: A term used to describe a woman who is "artificially" inseminated with the sperm of a man whose wife is unable or unwilling to bear a child, and who has agreed to give the baby to the couple after it is born. She is usually paid for this service. The term "surrogate mother" is misleading in this case, because the "surrogate" is in fact the true biological mother of the child. For this reason, the Ontario Advisory Council on Women's Issues has chosen to use the term birth mother and not "surrogate".

ULTRASOUND: Sends high frequency sound waves through the mother's abdomen. These sound waves bounce off the fetus and are converted into a picture on a video screen. Ultrasound is useful for detecting pelvic tumours or ectopic pregnancy and for confirming a multiple pregnancy or an abnormal fetal presentation (a fetus that is in some position other than head downward in the uterus). Ultrasound is also used as part of the in vitro fertilization process to locate and determine the size of egg follicles on the ovaries.

ENDNOTES

1. The choice to use "alternative insemination" as opposed to "artificial insemination" was made out of a desire to demystify this form of insemination, and to emphasize the fact that it is not a scientific "technology", but merely an alternative method of being inseminated.

2. Ontario Law Reform Commission (OLRC). *Report on Human Artificial Reproduction and Related Matter.* Ministry of the Attorney General, Volumes I and II, 1985.

3. With the exception of the OLRC Report, most of the governmental policy studies are concerned only with alternative insemination. See the following reports and recommendations:

   British Columbia, Royal Commission on Family and Children's Law. *Ninth Report of the Royal Commission on Family and Children's Law: Artificial Insemination.* Ministry of the Attorney General, 1975.

   Canada, Health and Welfare Canada. *Report of the Advisory Committee on the Storage and Utilization of Human Sperm*, 1981.

   Law Reform Commission of Saskatchewan. *Tentative Proposals for a Human Insemination Act*, 1981.

   Gouvernment du Quebec Conseil du statut de la femme. *General Opinion in Regard to New Reproductive Technologies.*

   National Association of Women and the Law. *Recommendations on Reproductive Technology*, 1989.

4. A number of policy documents have been published in other jurisdictions. However, only the New York Task Force on reproductive technologies reflects much concern for women from a feminist perspective. The Michigan legislation was formulated out of feminist sympathies and is now in force, but it has attracted constitutional challenges on the basis that it interferes with a fundamental right to bear or beget children. This litigation has thus far failed to invalidate the legislation, but it has been supported by the American Civil Liberties Association. (Surrogate Parenting Act, Michigan Comp. Laws Ann., ss. 710.54, 710.69; Doe v.Kelley, 106 Mich. App. 169, 307 N.W. 2d 438 (1990))

5. See re: *Ontario* Birth *Registration.* No. 88-05-045 856, 945-022 [1990] O.J. No. 608 (Ont Prov. Ct., February 12, 1990), per Walmsley A.C.J., in which the judge clearly concluded that under some circumstances, so called "surrogacy"

arrangements can be upheld by the courts of Ontario. In this case, a woman had agreed to marry her new spouse only after her own daughter became pregnant by his sperm so that the new couple could raise a child together. Walmsley J. allowed the birth registration to proceed with the new couple as the registered parents.

6. *OLRC* Report. Vol. II, 1985, pg. 139 - 285. The control of women recommended in this report goes much further than anything recommended or even contemplated by any other policy recommendations or judicial opinion.

7. In fact, the OLRC actually relies on this as the way doctors can avoid liability for discrimination against women who are single, disable, lesbian etc: "[A] physician cannot be forced to engage in a particular form of medical practice - for example, artificial insemination or in vitro fertilization. It would appear that refusal to provide such services to all persons would not, in itself, be sufficient ground to penalize a physician." OLRC *Report.* Vol. I, 1985. pg 55

8. There is some question about what constitutes responsible medical judgment regarding age and mental ability, since definitions are clouded by differences of opinions.

9. See Appendix I re: harms of reproductive technologies

10. Bills, reports and statutes that consider or provide for blanket criminalization of all parties to reproductive contracts, including all biological parties:

- OLRC (Ontario, Canada, 1985)
- Warnock Commission (UK, 1984)
- Surrogacy Arrangements Act (UK, 1985)
- Victoria, Australia (1984)
- US Federal (Luken) HR 2433 (1987)
- New York State Task Force (New York State, 1988)
- Arizona, V.2360, (1989), Act ASL14 (1989)
- Florida, Act 63.212(1) (1988)
- Kentucky, Act 199.590 (1988)
- Michigan, Act 199 (1988)
- Nebraska, Act 674 (1988)
- New York - B 2884 (1990)
- US Federal Bill, H.R. 275, H.R. 576 (1989)
- Utah, Act 140 (1989)
- Oregon B (1989)
- Michigan (Binsfield) B-228 (1987)
- Washington, Act 404 (1989)
- DC, B7-176 (1987)

11. Reports, bills and statutes that would criminalize commercial aspects but would exempt some or all of the biological parties or their partners:

-Warnock Commission, UK (1984)
-Surrogacy Arrangements Act, UK (1985)

12. There are no examples of this approach in existence, but there are some corollaries in the sexual harassment provisions of the Ontario Human Rights Code, the Minneapolis Anti-Pornography Ordinance, and United States Title VII discrimination legislation.

13. Reports, bills and statutes which use the null and void device in one way or another:

-OLRC (1985)
-Florida, 63.212(i) (1988)
-European Parliament, Larive-Groenendeal (1987)
-European Parliament, Russel proposal (1987)
-U.S.C.A.C., USA (1988)
-Warnock Report, UK (1984)
-Indiana Act, 31-8-2, 1-3 (1988)
-Kentucky Act, 199.590 (1988)
-Louisiana Act, 9:2713 (1987)
-Michigan Act, 199, (1988)
-Utah Act, 140 (1989)
-Washington Act, 404 (1989)
-DC, B7-176 (1987)
-North Dakota Act, 184 (1989)
-Uniform Status of Children of Assisted Conception Act, United States (1988)
-National Association of Women and the Law, Canada (1989)
-Britain's white paper (1987)
-Medical Procedures Act, Victoria Australia (1984)
-South Australia Working Party on IVF and AI (1984)
-New York State Task Force (1988)
-Surrogacy Arrangements Act, UK (1988)
-US Federal (Luken), HR 2433 (1987)
-New York State Task Force (1988)
-Arizona, V.2360, Act ASL14 (1989)
-Nebraska Act, 674 (1988)
-US Federal Bill, HR 275, HR 576 (1989)
-New York (Halpin) (1989)
-Michigan (Fitspatrick), Bill 4555
-Surrogate Parenting in New York (1987)

-Arkansas Resolution, 1013 (1989)
-New Jersey, Bill 12 (1990)
-Pennsylvannia, Bills 45 & 82 (1989)
-California, Bill 103 (1990)
-Massachusetts, Bill 565 (1990)
-New York (Connelly), Bill 6120 (1989)
-La Rev. Stat. Ann. s 9:2713

14. Reports, bills, statutes and commentaries that propose some version of an adoption model:

-Florida Act, 63.212 (1988)
-New Jersey (Kern) Bill 3038 (1986)
-New York (Dunne) (1987)
-European Parliament, Larrive-Groenendeal (1987)
-European Parliament, Russell Proposal (1987)
-Uniformed Status of Children of Artificial Conception, USA (1988)
-Warnock Report, UK (1984)
-Nevada Act, 127.303.5 (1987)
-Massachusetts (Morin) Bill 5314 (1987)
-Laurie Andrews. "Alternative Modes of Reproduction" in Reproductive Laws for the 1990s: A Briefing Handbook. Nadine Taub and Sherrill Cohen, Eds.,Rutgers, 1988. Pp. 259-297.

15. Bills and statutes that would apply a "best interests of the child" test to resolve parentage and custody of contract issues relating to children born under reproductive contracts:

-Indiana Act 31-8-2 (1988)
-Michigan Act 199 (1989)
-Utah Act 140 (1989)
-New York State Task Force (1988)
-New York (Halpin) (1987)
-Michigan (Fitzpatrick), Bill 4555
-Surrogate Parenting Act, Michigan Comp. Laws Ann s. 722:861

16. There is no clearcut line of authority on who the parents are and who should have custody of the child, when the child has been born as the result of a reproductive contract. In A. v. C., unreported (June 20, 1978, UK HCJ, Fam. Div.), aff'd, unreported (July 18, 1978, C.A.), per Comyn J., the UK Court of Appeal denied a putative "father" under a reproductive contract access to the resulting child, because the contract was void as against public policy; the judge

characterized the contract as "pernicious" because it was for the purchase and sale of a child. In contrast, in the Matter of Baby M, 217 NJ Super 313, 525 A. 2d 1128, 55 USLW 2544 (1978); 109 NJ 396, 537 A. 2d 1227, 56 USLW 2442 (1988); 225 NJ Super 267, 542 A. 2d 52 (1988), the New Jersey courts consistently denied the birth mother of the child any form of custody, but did, in the end, grant her supervised access for a few hours a week. In the Baby M case, the putative "father" became the father of record and the custodial father. A growing number of cases explore the range of outcomes such situations can generate.

17. See In the Matter of Baby M, supra, note 15. Although the child was to remain in the custody of the putative father and his wife, the birth mother was awarded some supervised access.

18. See, for example, In the Interest of R.C., 775 P. 2d 27, 58 USLW 2026 (Colo, 1989), in which the Supreme Court of Colorado ruled that a statute extinguishing parental rights of donors of semen does not apply when the mother is unmarried and has agreed that the donor will be treated as the father of the child. In that case, the court concluded that the conduct of the parties subsequent to the birth of the child would be dispositive of the parental status of the sperm donor. See also McIntyre v. Crouch, 98 Or. App 462, 780 P. 2d 239, 58 USLW2210 (Ore. App., 1989), in which the court remanded a sperm donor's applications to the trial court to determine whether he and the mother had agreed that the sperm donor should have the rights and responsibilities of fatherhood and whether his donation was made in reliance on such an agreement. Again, this disposition suggests that the course of conduct of the parties after birth is the key factor in deciding whether a man who donates sperm to a birth mother can accede to any of the prerogatives and responsibilities of parenthood.

19. In the Matter of the Adoption of Baby Girl L.J., 505 N.Y.S. 2d 813, 132 Misc 2d 972 (NY Surrogate's Court, 1986), held that the nonconsented adoption petition by the biological father and his spouse under a "surrogacy" agreement should be given effect in the best interests of the child, notwithstanding public aversion to such contracts. The birth mother in this case was allowed to keep the money promised for her services. But in the Matter of the Adoption of Paul, 550 N.Y.S. 2d 815 (1190), the court would terminate the birth mother's parental rights in an uncontested adoption under a reproductive contract only on the condition that she not seek or accept $10,000 payment for her services.

20. See In the Matter of Baby M, supra, note 15.

21. Child Welfare Act, R.S.O. 1980, c. 66; Child and Family Services Act, 1984, S.O. 1984, c. 55.

22. According to the Human Rights Code, Chapter 53, Part I, s. 1: "Every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin,

citizenship, creed, sex, sexual orientation, age, marital status, family status or handicap".

23. The Ontario government brought forward the Health Professionals Act which contains legislation for licensing midwives in Ontario. The Act is currently before the house and legislation is pending.

24. OLRC, Report. Vol. I, 1985, p 33.

25. In one line of cases, husbands have contested their liability to pay child support upon separation or divorce on the basis that the children were AI children and therefore they, the fathers, were not "parents" under the meaning of the applicable legislation. Generally, these husbands have been held liable, but the results in these cases have not been uniform. See, for example, In the Matter of Karin T. v. Michael T., 484 N.Y.S. 2d 780, 127 Misc. 2d 14 (1985), in which the husband was held liable; compare Anonymous v. Anonymous, 542 N.Y.S. 2d 586, 151 A.D. 2d 330 (1989), in which the court agree with the husband.

    In another line of cases, wives who have been involved in child custody suits have tried to terminate their husbands' parental rights because the children in question were AI children. In almost all these cases, the courts have held that even when the husband is not the biological father, he is still a parent. See, for example, Brooks v. Fair, 40 Ohio App. 3d 202, 532 N.E. 2d 208 (Ohio, 1988); Ex rel Coburn v. Coburn, 384 pa. Super 295, 558 A. 2d 548 (Pennsylvania, 1989).

26. Nancy D. Polikoff, "This Child Does Have Two Mothers: Redefining Parenthood to Meet the Needs of Children in Lesbian-Mother and Other Nontraditional Families", Georgetown *Law Journal* 78 (1990) 3:459, details several cases in which lesbian mothers who have a biological or legal connection with their children have taken the position, in custody litigation, that their former partners are not "parents" of their children. In some cases, the nonbiological mothers have lost not only custody of their children, but sometimes access to them as well. This line of argument has already appeared in Canadian litigation. See Anderson v. Luoma (1987) BCJ No. 600, per Carothers J.A., in which the nonbiological mother in a lesbian family relied on her lack of biological connection with the couple's AI children, persuaded the court that because she was not biologically connected she should not have to pay child support.

27. The Women's Health Bureau of the Ontario Ministry of Health.

ONTARIO
ADVISORY COUNCIL
ON WOMEN'S ISSUES

CONSEIL CONSULTATIF
DE L'ONTARIO SUR LA
CONDITION FÉMININE

880 rue Bay St., 5th Floor 5e étage, Toronto, Ontario M7A 1N3
Tel: (416) 326-1840 Fax: (416) 326-1836